STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365732	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austintown Healthcare Center	650 S Meridian Road Youngstown, OH 44509

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation and facility policy review, the facility failed to ensure Resident #3 had a fitted sheet placed on his bed. This affected one resident (#3) of six residents reviewed for clean, comfortable, homelike environment. The facility census was 87.Findings include:Review of Resident #3 's medical record revealed an admission date of 04/09/22 with diagnoses of fluid overload, localized edema, acute posthemorrhagic anemia, gastrointestinal hemorrhage, acute respiratory failure with hypoxia, epilepsy, not intractable, with status epilepticus, type II diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease, morbid (severe) obesity due to excess calorie, bipolar disorder, current episode mixed, adjustment disorder with mixed disturbance of emotions and conduct, chronic venous hypertension (idiopathic) with inflammation of bilateral lower extremity, mild cognitive impairment of uncertain or unknown etiology, diabetic neuropathy, intermittent explosive disorder, personal history of COVID-19, hyperlipidemia, lack of expected normal physiological development in childhood, cognitive communication deficit, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic sinusitis, atrial fibrillation, long term (current) use of insulin, gout, difficulty in walking, muscle weakness (generalized), and need for assistance with personal care.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was alert and oriented and cognitively intact. Resident #3 had impairment on both sides of upper and lower extremities in functional limitation of range of motion and was at risk for skin breakdowns.Observation on 03/23/26 at 11:13 A.M. revealed Resident #3 had no fitted sheet on his bed.Interview on 03/23/26 at 11:14 A.M. with Resident #3 revealed he rarely had a fitted sheet on his bed, the facility doesn't have fitted sheets to fit this size bed (bariatric bed). Interview on 03/23/26 at 11:13 A.M. with Housekeeping Director #250 confirmed no fitted sheet was on Resident #3 bed, and the facility does have issues getting fitted sheets to fit the bariatric bed. The facility usually uses flat sheets.Interview on 03/23/26 at 11:17 A.M. with Assistant Director of Nursing (ADON) #294 confirmed Resident #3 did not have a fitted sheet on his bed, and Resident #3 was lying on the bare mattress.Review of the undated, Resident Rights policy the facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents.This deficiency represents non-compliance identified under Complaint Number 2655564.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to report Resident #101's allegations of staff-to-abuse to the State agency. This finding affected one (Resident #101) of three residents reviewed for abuse. This facility census was 87.Findings include:Review of Resident #101's medical record revealed the resident was admitted on [DATE] and discharged on 02/18/26 with diagnoses including wedge compression fracture of the T7-T8 vertebra, repeated falls and bipolar disorder.Review of Resident #101's Witness Statement dated 12/22/25 revealed Curricular Practical Training Registered Nurse (CPT RN) #277 went into the resident's room to administer the morning medications, and the resident was seen trying to sit up by himself in bed. He asked the nurse to help him sit up, the nurse tried to help him sit up, and the resident became combative and abusive. The nurse told him she was sorry and they had only tried to pull him up as he asked for help.Review of Resident #101's Witness Statement dated 12/22/25 authored by Certified Nursing Assistant (CNA) #296 revealed the staff member observed the resident and nurse during medication pass and the resident was lying down. The resident asked for assistance, and the nurse assisted by holding wrists and assisting him to sit up. The resident became agitated and she stopped. The resident can be very combative and argumentative. The resident did not like the nurse and the new staff.Review of Resident #101's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition.Interview on 03/23/26 at 10:07 A.M. with the Director of Nursing (DON) revealed Resident #101 had problems with the Nigerian nursing staff and one staff member specifically (CPT RN Intern #277). Interview on 03/23/26 at 11:00 A.M. with the Administrator revealed Resident #101 did not report abuse. The Administrator indicated CPT RN Intern #277 pulled his hands to help him up and he felt it hurt his back. The Administrator confirmed the facility did not file an abuse Self-Reported Incident (SRI) with the State agency.Telephone interview on 03/23/26 at 11:54 A.M. with CPT RN Intern #277 indicated she walked into Resident #101's room to administer the resident's medications, and the resident was lying on his back. CPT RN Intern #277 felt the resident would choke on the medications and asked the resident to sit up. She stated the resident put his hands out and the nurse placed her hands in his and let him use her to move his body around to sit up. She denied pulling the resident by his hands at any point. CPT RN Intern #277 indicated the resident had reported she hurt him and she denied the allegation.Telephone interview on 03/24/26 at 10:17 A.M. with Ombudsman #298 revealed she called the Administrator on 12/29/25 and reported that Resident #101 had alleged physical abuse against one of the nursing staff. Ombudsman #298 indicated the Administrator did not file an SRI on behalf of Resident #101.Review of the undated Ohio Abuse, Neglect and Misappropriation policy revealed alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported no later than two hours after an allegation involving abuse and/or serious bodily injury. For alleged violations of neglect, exploitation, misappropriation of resident property, or mistreatment that do not result in serious bodily injury, the facility must report the allegation no later than 24 hours. The self-report will be made by the administration to the State Survey Agency and other local authorities including but not limited to, the local police if appropriate.This deficiency represents non-compliance investigated under Complaint Number 2696067.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure Residents #20 and #22's showers were completed as scheduled. This finding affected two (Residents #20 and #22) of ten residents who were dependent on staff for activities of daily living (ADL). The facility census was 87.Findings include:1. Review of Resident #20's medical record revealed the resident was admitted on [DATE], discharged to the hospital on [DATE] and returned on 03/12/26 with diagnoses including atherosclerotic heart disease, vascular dementia and cognitive communication deficit.Review of Resident #20's ADL care plan revealed an intervention dated 01/30/26 stating the resident required substantial/maximal assistance with showering/bathing.Review of Resident #20's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment and required substantial/maximal assistance with showering/bathing.Review of shower schedule confirmed Resident #20's showers were scheduled Tuesday, Thursday and Saturday on dayshift from 7:00 A.M. to 3:00 P.M.Review of shower sheets from 02/24/26 to 03/24/26 revealed no documented evidence that Resident #20 received showers on 02/24/26, 02/26/26, 02/28/26 and 03/14/26. Further review revealed the resident was set up to wash in the bathroom sink on 03/17/26, 03/19/26 and 03/21/26.Interview on 03/23/26 at 9:49 A.M. with Resident #20 revealed the resident was not receiving showers as scheduled.Interview on 03/24/26 at 1:00 P.M. with Registered Nurse (RN) Regional #300 confirmed the above findings.2. Review of Resident #22's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, low back pain and essential hypertension.Review of Resident #22's ADL care plan revealed an intervention dated 03/09/26 indicating the resident required substantial/maximal assistance with showering/bathing.Review of the shower schedule revealed Resident #22 was scheduled for showers Tuesday, Thursday and Saturday on dayshift from 7:00 A.M. to 3:00 P.M.Review of Resident #22's shower sheets revealed no documented evidence showers were completed on 02/24/26, 02/26/26, 02/28/26, 03/03/26 and 03/05/26. Further review, the resident received bed baths on 03/07/26, 03/10/26, 03/12/26 and showers on 03/17/26, 03/19/26 and 03/21/26.Interview on 03/23/26 at 10:34 A.M. with Resident #22 revealed showers were not completed as scheduled.Interview on 03/24/26 at 1:00 P.M. with RN Regional #300 confirmed the above findings.Review of the undated Routine Resident Care policy revealed it was the policy of the facility to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident lifestyle preferences while in the care of the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure Residents #4 and #90's pressure ulcer wound care was completed as ordered. This finding affected two (Residents #4 and #90) of four residents reviewed for pressure wounds. The facility census was 87.Findings include:1. Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinsonism, weakness and peripheral vascular disease. Review of Resident #4's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #4's skin and wound care plan revealed an intervention dated 02/18/26 to administer treatments as ordered by the medical provider. Review of Resident #4's physician orders revealed an order dated 03/05/26 to cleanse the coccyx pressure ulcer with normal saline, apply medical grade honey and calcium alginate to the base of the wound, secured with a bordered foam dressing daily and as needed. Review of Resident #4's Wound Assessment Report dated 03/19/26 revealed the resident had a Stage II (partial-thickness skin loss involving the epidermis and dermis) pressure wound which was improving and measured 0.70 centimeters (cm) length by 0.80 cm width by 0.10 cm depth. Review of Resident #4's medication administration records (MAR) and treatment administration records (TAR) from 03/05/26 to 03/24/26 revealed no documented evidence wound care was completed on 03/07/26, 03/08/26, 03/09/26, 03/10/26, 03/17/26 and 03/18/26. Interview on 03/23/26 at 10:03 A.M. with Regional Nurse (RN) Regional #300 confirmed Resident #4's medical record did not contain documented evidence treatments were completed as ordered for eight dates as identified above. Observation on 03/23/26 at 1:48 P.M. with Licensed Practical Nurse (LPN) #218 of Resident #4's sacrum wound care revealed the dressing was dated 03/21/26. The observation confirmed that the wound care was not completed on 03/22/26 as ordered by the physician. Interview on 03/23/26 at 1:50 P.M. with LPN #218 confirmed Resident #101's sacral dressing was not changed as ordered. 2. Review of Resident #90's medical record revealed the resident was admitted on [DATE] with diagnoses of intraspinal abscess and granuloma, infection of intervertebral disc cervical region and dysphagia. Record review of care plan dated 02/23/26 revealed Resident #90 had impaired skin integrity or at risk for altered skin integrity due to surgical neck incisions and deep tissue injury (DTI), a DTI is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear, to the left buttock. Interventions included administer treatments as ordered by the medical provider. Review of Resident #90's MDS assessment dated [DATE] revealed the resident was cognitively (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intact and required substantial/maximal assistance with activities of daily living (ADL) Review of Resident #90's Wound Assessment Report dated 03/05/26 revealed a Stage III pressure ulcer (a full-thickness skin loss injury appearing as a deep crater like wound where subcutaneous fat may be visible) which was improving, measured 3.0 cm wide by 3.0 cm long by 0.10 cm depth. Medical record review for Resident #90 revealed physician orders dated 03/05/26 for wound treatment to a pressure ulcer located on the left buttock which included cleanse with normal saline, apply Triad past to base of wound and secure with silicone bordered superabsorb, and change daily and as needed (PRN). Review of the TAR for the period of 03/01/26 through 3/31/26 showed missed/undocumented treatments on the following dates: 03/08/26, 03/10/26. There was no documented clinical justification for the missed treatments. Interview on 03/23/26 at 11:11 A.M. RN Regional #300 confirmed the wound treatment was ordered as noted but acknowledged treatments were not completed as scheduled. Record review of the undated Skin Care & Wound Management Overview policy revealed in section Treatment: Pressure Ulcer Documentation complete for all pressure ulcers, Skin Impairment Documentation, complete for all skin impairment issues that require measurement to indicate if healing is occurring, review and select the appropriate treatment for the identified skin impairment, obtain a physician's order, document treatment in the Electronic Treatment Administration Record (ETAR), monitor and document progress.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure Resident #4's tracheostomy care was completed as ordered. In addition, the facility failed to ensure Resident #3's oxygen tubing was dated and the humidifier canister had available solution for humidification. This finding affected two (Residents #3 and #4) of three residents reviewed for respiratory care. The facility census was 87.Findings include:1. Review of Resident #4's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinsonism, weakness and peripheral vascular disease. Review of Resident #4's physician orders revealed an order dated 02/10/26 for trach care every shift and as needed. Review of Resident #4's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #4's tracheostomy care plans revealed an intervention dated 03/04/26 to administer treatments per the medical provider's orders and observe for side effects and effectiveness. Review of Resident #4's treatment administration (TAR) revealed the trach care was due dayshift and nightshift. Review of the TAR from 03/01/26 to 03/24/26 revealed no documented evidence trach care was completed on dayshift for the dates of 03/03/26, 03/05/26, 03/08/26, 03/10/26, 03/13/26, 03/17/26, 03/18/26 and 03/19/26. Interview on 03/24/26 at 2:40 P.M. with Registered Nurse (RN) Assistant Director of Nursing (ADON) #294 confirmed the above findings. Review of the undated Tracheostomy Care policy revealed the purpose of the policy was to provide guidance for tracheostomy care for the licensed and competent nurse or respiratory therapist. Process steps may be performed using a different sequence and did not imply incorrect procedure. Maintaining key areas of aseptic technique and working efficiently to resume oxygenation were the critical components of the process. Tracheostomy care was typically completed twice per day and as needed, the inner cannula changed once per day and as needed, and the tracheostomy ties changed three times a week and as needed. Confirm the practitioner order before performing tracheostomy care. 2. Review of Resident #3 's medical record revealed an admission date of 04/09/22 with diagnoses of fluid overload, localized edema, acute posthemorrhagic anemia, gastrointestinal hemorrhage, acute respiratory failure with hypoxia, epilepsy, not intractable, with status epilepticus, type II diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease, morbid (severe) obesity due to excess calorie, bipolar disorder, current episode mixed, adjustment disorder with mixed disturbance of emotions and conduct, chronic venous hypertension (idiopathic) with inflammation of bilateral lower extremity, mild cognitive impairment of uncertain or unknown etiology, diabetic neuropathy, intermittent explosive disorder, personal history of COVID-19, hyperlipidemia, lack of expected normal physiological development in childhood, cognitive communication deficit, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic sinusitis, atrial fibrillation, long term (current) use of insulin, gout, difficulty in walking, muscle weakness (generalized), and need for (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with personal care. Review of the Quarterly MDS 3.0 assessment dated [DATE] revealed Resident #3 was cognitively intact. This assessment reflected Resident #3 use of oxygen for respiratory failure. Review of the current care plan for Resident #3 has oxygen therapy for respiratory failure and will have no signs and symptoms of poor oxygen absorption. Review of the physician order originally dated 03/03/26 revealed the oxygen tubing and humidifier were to be changed every week on Sundays and as needed. Resident #3 oxygen order was 4 liters per minute (LPM) via nasal cannula continuously. Review of the TAR for March 2026 indicated the oxygen tubing and humidifier were due to be changed on 03/22/26. The oxygen tubing was not dated, and the humidifier cannister was empty. Interview with RN ADON #294 on 03/23/26 at 11:17 A.M. confirmed Resident #3 had an order for her oxygen tubing and humidifier to be changed weekly on Sundays and as needed. ADON #294 confirmed there was no date on the oxygen tubing, and the humidifier canister was empty. Review of the undated facility policy titled, Supplemental Oxygen using Nasal Cannula Policy nasal cannula and tubing will be labeled and dated when opened and revealed all residents utilizing oxygen will have the tubing changed on a weekly basis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and facility policy review, the facility did not ensure resident records contained accurate documentation. This affected three (Residents #2, #11, and #49) of 33 resident records reviewed for medical record accuracy. The facility census was 87. Findings include:1. Record review revealed Resident #49 was admitted [DATE] with diagnoses of Parkinsonism, chronic obstructive pulmonary disease (COPD), and interstitial emphysema. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was cognitively intact and required moderate assistance with toileting hygiene and personal hygiene and maximal assistance with showers dressing, and transfers. Review of the March 2026 physician orders revealed Resident #49 had an order for carbidopa-levodopa-entacapone 200 milligram (mg) tablet every three hours for Parkinson's. The administration times were midnight, 3:00 A.M., 6:00 A.M., 9:00 A.M., 12:00 P.M., 3:00 P.M., 6:00 P.M., and 9:00 P.M.Review of the March 2026 Medication Administration Record (MAR) revealed the nurse did not document receipt of carbidopa-levodopa-entacapone on 03/07/26, 03/14/26, and 03/19/26 at 6:00 P.M.Interview on 03/25/26 at 9:55 A.M. with Assistant Director of Nursing (ADON) #294 confirmed documentation on 03/07/26, 03/14/26, and 03/19/26 at 6:00 P.M. were missing for Resident #49. Review of the progress notes revealed Resident #49 had a care conference on 01/22/26; however, it was not documented until 02/03/26.Interview on 03/26/26 at 8:27 A.M. with the social worker confirmed the care conference was documented late for Resident #49.2. Record review revealed Resident #2 was admitted [DATE] with diagnoses of end stage renal disease, type II diabetes mellitus with diabetic neuropathy, heart failure, and dementia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #2 was dependent on staff for toileting hygiene, showers, dressing, and transfers, and maximal assistance for oral hygiene, and personal hygiene.Review of the March 2026 physician orders revealed Resident #2 had orders for docusate sodium (stool softener) 100 mg once daily, frozen nutritional treat one time a day, omeprazole (reduces stomach acid) 40 mg, ferrous sulfate (iron supplement) 325 mg once daily, daily vitals, midodrine hydrochloride (treats low blood pressure upon standing) 10 mg three times daily, and sevelamer carbonate (controls high levels of phosphorus) 800 mg three times daily.Review of the March 2026 MAR revealed the following: the nurse did not document administration of docusate sodium, omeprazole, and vital signs on 03/11/26; frozen treat, ferrous sulfate, midodrine hydrochloride, and sevelamer carbonate on 03/14/25.Interview on 03/25/26 at 9:55 A.M. with ADON #294 confirmed the above documentation was incomplete for Resident #2.3. Record review revealed Resident #11 was admitted [DATE] with diagnoses of severe protein calorie malnutrition, type II diabetes without complications, and unspecified dementia.Review of the quarterly MDS assessment dated [DATE] revealed Resident #11 was moderately cognitively impaired and dependent on staff for toileting hygiene, showers, dressing, personal hygiene, and transfers. Review of the march 2026 physician orders revealed Resident #11 had an order to check placement of the Fentanyl patch (opioid pin medication) every four hours and document placement of patch.Review of the March 2026 MAR revealed placement was not documented on 03/22/26 at 2:00 P.M.Interview on 03/25/26 at 9:55 A.M. with ADON #294 confirmed placement was not checked for Resident #2.Review of the undated Clinical Documentation Standards Policy revealed nurses were to follow the basic standard of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to provide a resident room that was in good repair for one (Resident #39) of six residents reviewed for physical environment. The facility census was 87.Findings include:A review of medical records for Resident #39 revealed an admission date of 09/24/25. Significant diagnoses included Parkinson's disease without dyskinesia, without mention of fluctuations, and altered mental status.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) with a score of three out of 15, indicating Resident #39 had severe cognitive impairment.Review of the care plan dated 01/13/26 revealed no indications for Resident #39 refused housekeeping and maintenance services.An observation on 03/23/26 at 1:59 P.M. revealed the room for Resident #39 was in general disrepair. The chair rail had splintered wood. Observation on 03/24/26 at 10:01 A.M. revealed the resident's bed was in a low position horizontal to wall with the splintered wood approximately four feet long on the chair rail.Interview with Director of Plant Maintenance #267 on 03/24/26 at 10:06 A.M. confirmed the chair rail was in disrepair and needed replacement at the time of the observation.Review of undated Resident Rights policy revealed it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care.This deficiency represents non-compliance investigated under Complaint Number 2655564.